

AMENDED IN ASSEMBLY JULY 7, 1999

**SENATE BILL**

**No. 559**

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**Introduced by Senator Brulte**

February 19, 1999

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An act to add Section 511.1 to the Business and Professions Code, to add Section 1395.6 to the Health and Safety Code, to add Sections 10178.3 and 11580.03 to the Insurance Code, and to add Section 4609 to the Labor Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 559, as amended, Brulte. Health care providers: preferred rates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Corporations. Under existing law, a willful violation of health care service plan requirements is a crime. Existing law also provides for the regulation of insurers by the Department of Insurance.

This bill would provide that a payor, as defined, is not entitled to claim or pay a preferred rate for health care services provided by health care providers to beneficiaries, unless the payor is a qualified payor meeting certain conditions. This bill would define "payor" to include a health care service plan, a specialized health care service plan, a disability or liability insurer that provides coverage for hospital, medical, or surgical expenses, a workers' compensation insurer, an employer, or any other 3rd party that is responsible to pay for health care services provided to

beneficiaries by health care providers. This bill would enact other related provisions.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program by creating a new crime.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 511.1 is added to the Business  
2 and Professions Code, to read:

3 511.1. (a) As used in this section, the following terms  
4 have the following meanings:

5 (1) "Beneficiary" means an individual who receives  
6 health care services from a provider, which services are  
7 paid for by a payor.

8 (2) "Contracting agent" means an individual or entity  
9 that, for monetary or other consideration, sells, leases,  
10 assigns, transfers, or otherwise conveys or arranges the  
11 availability of a provider or provider panel to provide  
12 health care services to beneficiaries. A contracting agent  
13 may include, but is not limited to, a health care service  
14 plan, a specialized health care service plan, a third-party  
15 administrator, a preferred provider organization, an  
16 independent practice association, or a medical group.

17 (3) "Eligible beneficiary" means a beneficiary whose  
18 care is being paid for by a qualified payor pursuant to a  
19 program that provides direct financial incentives to the  
20 eligible beneficiary for utilizing a provider or provider  
21 panel, and who is able to present, at the time of service,  
22 a current identification card issued by the payor, or is  
23 otherwise able to reasonably demonstrate, at the time of

1 service, current eligibility to receive health care service  
2 at the preferred rate. “Financial incentives” means  
3 reduced copayments, reduced deductibles, or premium  
4 discounts directly attributable to the use of a provider  
5 panel.

6 (4) “Payor” means a health care service plan, a  
7 specialized health care service plan, a disability or liability  
8 insurer that provides coverage for hospital, medical, or  
9 surgical expenses, a workers’ compensation insurer, an  
10 employer, or any other third party that is responsible to  
11 pay for health care services provided to beneficiaries.

12 (5) “Payor summary” means a written summary that  
13 includes, but is not limited to, all of the following:

14 (A) The payor’s name.

15 (B) The type of plan, including, but not limited to, a  
16 group health plan, an automobile insurance plan, and a  
17 workers’ compensation plan.

18 (C) The type of payor, including, but not limited to, a  
19 health care service plan, a specialized health care service  
20 plan, a disability, liability, or workers’ compensation  
21 insurer, or a self-insured employer.

22 (D) The financial incentives, if any, to beneficiaries to  
23 seek care from a provider panel.

24 (E) The type of coverage, including, but not limited  
25 to, chiropractic, hospitalization, medical, dental, and  
26 vision coverage.

27 (F) The method by which to identify eligible  
28 beneficiaries.

29 (G) The method by which to verify eligibility,  
30 authorization requirements and procedures, copayment  
31 requirements, and claim submission requirements and  
32 procedures.

33 (6) “Preferred rate” means the rate at which a  
34 provider has agreed to provide services to eligible  
35 beneficiaries and to other beneficiaries under the  
36 conditions specified in this section.

37 (7) “Preferred rate agreement” means a written  
38 agreement between a provider and a contracting agent  
39 or a payor that clearly states the preferred rate and  
40 includes a payor summary for each payor entitled to pay

1 the preferred rate or clearly describes the types of payors  
2 and applicable conditions under which a contracting  
3 agent may offer or extend the preferred rate to a payor  
4 or other contracting agent.

5 (8) “Provider” means any of the following:

6 (A) Any person licensed or certified pursuant to this  
7 division.

8 (B) Any person licensed pursuant to the Osteopathic  
9 Initiative Act.

10 (C) Any person licensed pursuant to the Chiropractic  
11 Initiative Act.

12 (D) Any person licensed pursuant to Chapter 2.5  
13 (commencing with Section 1440) of Division 2 of the  
14 Health and Safety Code.

15 (E) A clinic, health dispensary, or health facility  
16 licensed pursuant to Division 2 (commencing with  
17 Section 1200) of the Health and Safety Code.

18 (F) Any entity exempt from licensure pursuant to  
19 Section 1206 of the Health and Safety Code.

20 (9) “Provider panel” means a group of providers, each  
21 of whom has entered into a preferred rate agreement  
22 with a contracting agent, which agreement permits the  
23 contracting agent to commit a provider or a provider  
24 panel to the provision of health care services to eligible  
25 beneficiaries pursuant to a preferred rate, and to other  
26 beneficiaries under conditions set forth in this section.

27 (10) “Qualified payor” means ~~any~~ *either* of the  
28 following:

29 (A) A payor who is entitled to pay a preferred rate for  
30 a provider’s services by virtue of meeting all of the  
31 following conditions:

32 (i) The payor has entered into either a preferred rate  
33 agreement with the provider, or the payor has entered  
34 into a written agreement with a contracting agent, which  
35 written agreement clearly discloses the parties to the  
36 preferred rate agreement, and which directly or  
37 indirectly qualifies the payor to receive the preferred  
38 rate.

39 (ii) The preferred rate shall apply only to claims for  
40 eligible beneficiaries.

(iii) The preferred rate shall only apply prospectively to services rendered after the effective date of the written agreement described in clause (i).

(iv) The payor provides an explanation of benefits that identifies the specific preferred rate agreement whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(B) A payor who has been specifically authorized, by a written agreement signed by a provider who has received a payor summary, to pay the provider's preferred rate for services to the payor's beneficiaries. The preferred rate in this case shall apply only prospectively to services rendered after the effective date of the written agreement and only if the payor provides an explanation of benefits that identifies the specific preferred rate agreement whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

~~(C) A payor who is entitled to pay a preferred rate for a provider's services by virtue of meeting all of the following conditions:~~

~~(i) The payor, either directly or indirectly through a contracting agent, has given the provider from whom the payor wishes to apply a preferred rate, all of the following: a payor summary, written notice of the payor's intent to apply the providers' preferred rate, and a period of 30 days for the provider to decline to participate in any proposed agreement.~~

~~(ii) The preferred rate shall apply only prospectively to services rendered after the expiration of the period described in clause (i).~~

~~(iii) The payor provides an explanation of benefits that identifies the specific preferred rate agreement whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.~~

(b) No payor shall be entitled to claim or pay a preferred rate for health care services to beneficiaries, unless the payor is a qualified payor.

(c) A contracting agent shall disclose, within 30 days of receipt of a written request from a provider or a provider

1 panel, the payor summary of each payor with whom it has  
2 directly contracted, or the name, address, telephone  
3 number, and ~~contract~~ *contact* name of each contracting  
4 agent with whom it has directly contracted.

5 (d) A contracting agent shall not terminate, limit,  
6 nonrenew, or otherwise impair any existing contract or  
7 employment of a provider, or the participation of a  
8 provider on a provider panel on the basis that the  
9 provider refuses to contract with additional payors  
10 pursuant to the provisions ~~—subparagraph (B) or (C) of~~  
11 *subparagraph (B)* of paragraph (10) of subdivision (a).

12 (e) A payor who has not complied with the conditions  
13 of subparagraph (A), ~~(B), or (C)~~ *or (B)* of paragraph  
14 (10) of subdivision (a) shall pay the provider's standard  
15 nondiscounted reasonable charges for services rendered  
16 to beneficiaries. A payor shall reasonably demonstrate  
17 that it is entitled to pay a preferred rate by virtue of being  
18 a qualified payor within 30 days of receipt of a written  
19 request from a provider. The failure of a payor to  
20 reasonably and timely demonstrate that it is entitled to  
21 pay a preferred rate shall render the payor liable for the  
22 ~~provider's standard nondiscounted reasonable charges,~~  
23 ~~which charges amount the provider would have been~~  
24 ~~entitled to be paid absent any preferred rate agreement,~~  
25 ~~which amount~~ shall be due and payable within 10 days of  
26 receipt of written notice from the provider that a payor  
27 has not reasonably and timely demonstrated its  
28 entitlement to a preferred rate.

29 (f) If a provider is required to take legal action to  
30 collect its standard reasonable charges *based on the*  
31 *requirements of this section*, it shall be entitled to the  
32 greater of five hundred dollars (\$500) or an amount that  
33 is twice the ~~provider's standard reasonable charges~~  
34 *amount the provider would have been entitled to be paid*  
35 *absent any preferred rate agreement*, in addition to  
36 reasonable attorney's fees and costs.

37 (g) Nothing in this section is intended to interfere with  
38 a payor's right to establish or determine eligibility or  
39 coverage of a beneficiary.

SEC. 2. Section 1395.6 is added to the Health and Safety Code, to read:

1395.6. A health care service plan or a specialized health care service plan that is a payor, as defined in paragraph (4) of subdivision (a) of Section 511.1 of the Business and Professions Code, shall comply with the requirements of that section.

SEC. 3. Section 10178.3 is added to the Insurance Code, to read:

10178.3. A disability insurer that provides coverage for hospital, medical, or surgical expenses and that is a payor, as defined in paragraph (4) of subdivision (a) of Section 511.1 of the Business and Professions Code, shall comply with the requirements of that section.

SEC. 4. Section 11580.03 is added to the Insurance Code, to read:

11580.03. A liability insurer that provides coverage for hospital, medical, or surgical expenses and that is a payor, as defined in paragraph (4) of subdivision (a) of Section 511.1 of the Business and Professions Code, shall comply with the requirements of that section.

SEC. 5. Section 4609 is added to the Labor Code, to read:

4609. A workers' compensation insurer or a self-insured employer that is a payor, as defined in paragraph (4) of subdivision (a) of Section 511.1 of the Business and Professions Code, shall comply with the requirements of that section.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.